Authorization for Release of Medical Records

_____ ("Patient") of _____(Address), with Social Security Number _____, hereby authorizes the release, disclose, and delivery of the medical information described below to: _____
(Authorized Recipient).

Specific Authorization. I specifically authorize the release of all medical information relating to the above-named patient including but not limited to the following categories protected by state or federal law: (1) Substance abuse (drug or alcohol) treatment (2) Mental health treatment and (3) HIV-AIDS-related information, if such information is contained in the records. This request includes any reports, correspondence, test results, and any other information contained in the records, whether generated by the authorized provider or another entity.

I do not give permission for any other use or redisclosure of this information.

Yours very truly,

_____
Patient

Redisclosure. This release does not authorize redisclosure of medical information beyond the limits of this consent. The Recipient of this information is prohibited from using the information for other than the stated purpose, and from disclosing it to any other party without further authorization from me, the patient. The following written statement should accompany certain disclosures:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

The Patient specifically understands and agrees that the REDISCLOSURE requirements set out above will apply to these records.

Validity and Time Period. I understand that this authorization will automatically expire one year from the date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

I authorize the release of information as indicated above.

_____ Date: _____
Patient

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Review List

This review list is provided to inform you about the document in question and assist you in its preparation. Remember to include the cover letter and read the review list prior to doing so.

1. The Authorization must be signed and dated in two places by the patient or the patient's authorized representative, such as a parent for a minor. The first signature specifies what medical records can and cannot be released. The second signature relates to the entire form.

2. Send two signed copies to the health care provider. They can keep one set and send you back the other.

3. If this release is for litigation purposes, your litigation lawyer should handle the matter directly with the Health Care Provider on your behalf.